

**ATTAINING UNIVERSAL HEALTH COVERAGE
IN NIGERIA USING THE NATIONAL
HEALTH INSURANCE SCHEME**

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ATTAINING UNIVERSAL HEALTH COVERAGE IN NIGERIA USING THE NATIONAL HEALTH INSURANCE SCHEME

A thesis submitted in partial fulfilment of the requirement for the Degree of Master of Public Health

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Declaration:

Where other people's work has been used (either from a printed source, internet or any other source), this has been carefully acknowledged and referenced in accordance with departmental requirements. The thesis "**Attaining Universal Health Coverage in Nigeria using the National health Insurance Scheme**" is my own work.

Signature:

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LIST OF ABBREVIATION

| | |
|--------|---|
| ART | Anti-retroviral Therapy |
| CBHI | Community Based Health Insurance |
| FSSHIP | Formal Sector Social Health Insurance Programme |
| GDP | Gross Domestic Product |
| GGE | General Government Expenditure |
| GGHE | General Government Health Expenditure |
| HDI | Human Development Index |
| HIV | Human Immunodeficiency Virus |
| HMO | Health Maintenance Organisation |
| HSF | Health Sector Financing |
| ITN | Insecticide Treated Net |
| NDHS | Nigeria Demographic And Health Survey |
| NHIS | National Health Insurance Scheme |
| NLCP | National TB and Leprosy Control Programme |
| OOP | Out of Pocket Payment |
| PHI | Private Health Insurance |
| PvtHE | Private Health Expenditure |
| SDG | Sustainable Development Goals |
| THE | Total Health Expenditure |
| UHC | Universal Health Coverage |
| WHR | World Health Report |

ABSTRACT

Background: The Federal Government of Nigeria instituted the National Health Insurance Scheme in 2005 with an aim to remove financial impediments to healthcare for the Nigerian population and assist in attaining Universal Health Coverage. More than one decade on, the scheme is faced with several challenges making it largely ineffective with just about 5% of the population enrolled on the scheme.

Objective: To review the National Health Insurance Scheme in Nigeria and compare its functionalities to neighbouring countries; in order to offer strategies and make recommendations that will help it achieve UHC through effective and adequate health insurance.

Methodology: A review of literature was conducted using studies from peer reviewed journals on the subject of National Health Insurance Scheme within the context of Nigeria. The WHO OASIS framework was used to analyse the findings.

Findings: Government's budgetary allocation to the health sector is low while health insurance coverage for the Nigerian population is significantly low. Less than 5% of the population is covered by the National Health Insurance, mainly in the formal sector. Out-of-pocket payments for healthcare is significantly high with the potential for catastrophic health expenditures.

Conclusion: Nigeria's inability to meet targets set for achieving universal health coverage is due to inadequate funding for the health sector, challenges faced by the National Health Insurance Scheme, human resource and infrastructural challenges and insufficient stakeholder engagement

Recommendations: Government should strengthen its commitment towards health by increasing budgetary allocation to health to at least 15% recommended. Health Insurance should be made compulsory for all citizens while innovative revenue generation

Key words: Nigeria, National Health Insurance Scheme, Universal Health Coverage, Health Financing, Community Based Health Insurance, Health Financing

Word Count: 12,000

INTRODUCTION AND ORGANISATION OF THE THESIS

Health is a fundamental human right and affordable health services of good quality should be available for everyone irrespective of one's social class or geographical location. In recognition of this fact, WHO introduced the concept of Universal Health Coverage (UHC) as a means to achieving equitable access to promotive, preventive, curative, rehabilitative and palliative quality health services for all people while ensuring good protection against financial hardship (1).

Many countries have adopted different strategies towards attaining UHC. The Federal Government of Nigeria instituted the National Health Insurance Scheme in 2005 to eliminate financial impediments to healthcare for all Nigerians. However, lack of proper implementation of the scheme and poor enrolment has reduced the expected increase in health coverage. Less than 5% the population is covered by the scheme.

Health insurance is a recognized strategy of achieving UHC. Although, Nigeria's plan of attaining UHC using NHIS is a step in the right direction, measures must be taken to address the challenges of the scheme. During my work in Nigeria as a medical doctor, I observed situations where patients' conditions deteriorated because they were not able to afford treatment. My interest in this topic lies in identifying the challenges faced by the scheme and identifying evidenced-informed interventions to address the challenges. Careful assessment of the efforts, prospects and challenges of the NHIS will provide a good platform to formulate ideas capable of increasing health coverage in Nigeria, hence the need for this review. This thesis is organized in five chapters:

- Chapter one presents background information and an overview of the health system with a focus on health financing
- Chapter two presents the problem statement, justification, objectives and methodology for the study
- Chapter three presents the findings from the review of literature on the subject
- Chapter four analyses the implementation of health insurance in other African countries and draws lessons for Nigeria
- Chapter five discusses the findings in the literature analysis and
- Chapter six presents conclusions and recommendations for policy change

CHAPTER ONE: BACKGROUND INFORMATION ABOUT NIGERIA

1.1 Introduction

This chapter presents background information about the Federal Republic of Nigeria. It first describes the demography, socioeconomic situation and a general overview of the health system. It then focuses on the situation with regards to health financing in the country.

1.2 Geography

The Federal Republic of Nigeria is found in West Africa and occupies a landmass of approximately 923, 768 square kilometres (2). It is bounded in the north by Chad and Niger; in the east by Cameroon and in the west by Benin. (2). The topography of the country has two main land forms: lowlands and highlands (2). Nigeria has a tropical climate with rainy season from April to September and dry season from October to March (2). Figure 1 presents the map of Nigeria.

Figure 1: Political map of Nigeria



Source: Ezilon maps (3)

1.3 Demography

Nigeria is the most populated country in Africa with estimated 182 million population in 2015 and an annual growth rate of 2.5% (4) 51% of the population is female while 49% are male with median age in the general population estimated at 18 years (2). About 52% of the population live in rural areas (5).

1.3 Socio-economic Situation

The mainstay of Nigeria's economy is the services sector which contributes 54.8% to the country's gross domestic product (GDP) followed by agriculture which contributes 20.2%; whilst the petroleum and oil industry contributed to 10.8% to GDP in 2014 (5). Nigeria is a lower middle income country and has an estimated GDP of \$481.066 billion in 2015; GDP per capita is estimated at \$2640 (5).

1.4 General Health Profile

Life expectancy in Nigeria is estimated at 54 years (6) whilst the total fertility rate is estimated at 5.7 (7). The country is currently undergoing an epidemiological transition with increased incidence of non-communicable diseases (NCDs) accounting for 24% of total deaths in 2014 (8). However, communicable diseases are still the leading cause of mortalities in the country accounting for 66% of all deaths in 2014 (8). Table 1 presents selected health indicators for the country.

Table 1: Selected Health Indicators for Nigeria

| Indicator | Value |
|--|-------|
| Under-five mortality rate (per 1000 live births) | 117 |
| Maternal mortality rate (per 100,000 live births) | 560 |
| Deaths due to HIV/ AIDS (per 100,000 population) | 128.7 |
| Deaths due to malaria (per 100,000 population) | 106.9 |
| Deaths due to malaria among HIV-negative people (Per 100,000 population) | 94 |
| Total fertility rate per woman | 6.0 |

Source: WHO statistical profile (6)

1.5 Overview of the health system

The Federal Ministry of health is the body in-charge of coordinating health related activities and agencies in Nigeria (9). The healthcare delivery system is organized into primary, secondary and tertiary levels while it is managed at the local government, secondary government and federal government level

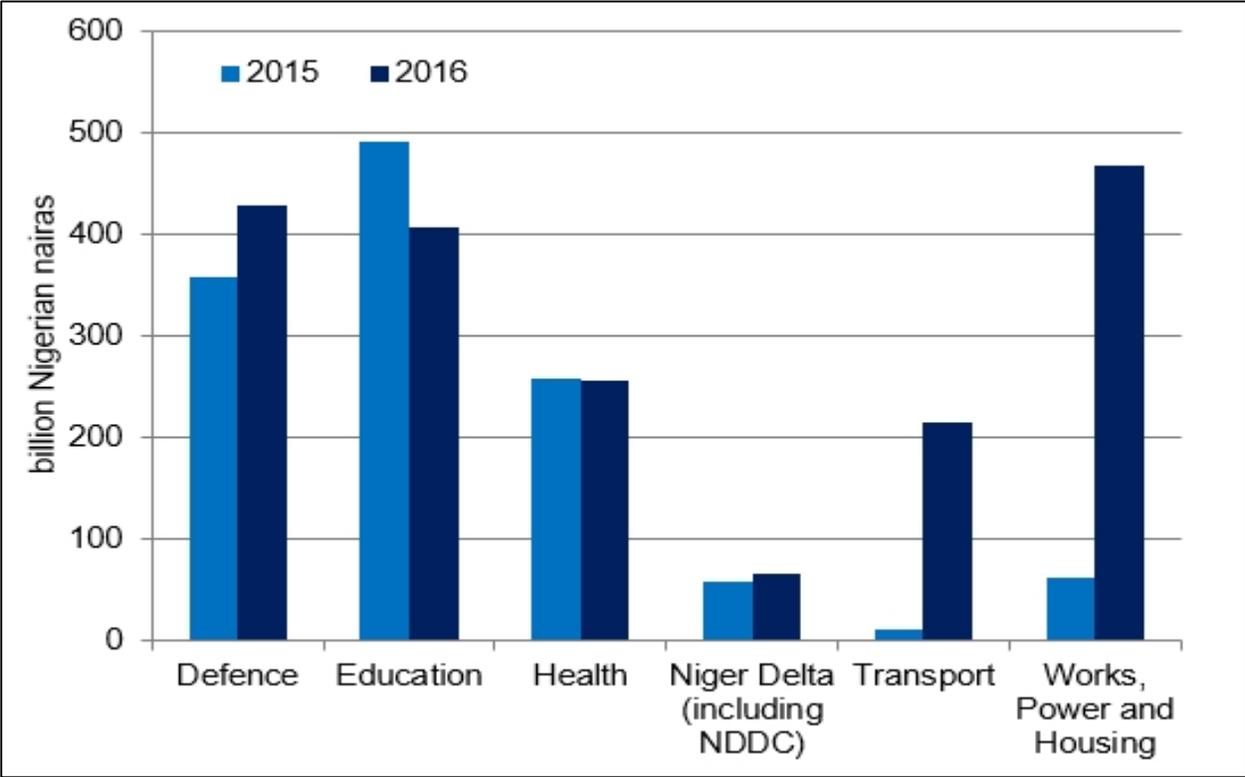
respectively (10). Both private and public health sector provide services in Nigeria under the coordination of the Ministry of Health (10). The health workforce ranges from skilled health professionals like doctors, nurses to non-skilled health providers like traditional birth attendants and patent drug dealers (10). Public health facilities include federal teaching hospitals, federal medical centres in each state, some specialist hospitals like orthopaedics and psychiatry hospital, general hospitals and primary health centres (11). The private health sector is both for profit and not-for-profit which includes non-governmental organizations (NGO), private practitioners, community based organizations and faith based organizations, profit and non-health provider (12). Donors both local and international provide support to specific programs like HIV, TB and malaria control through partnership with public health authorities (11). However, private health sector providers are the most commonly used healthcare delivery service in Nigeria context (11). The quality of services provided has been questioned while enforcement of regulations is poor (11). Although more than half of the population reside in rural areas, there is a significant disparity in terms of availability and access to healthcare services between rural and urban dwellers (10).

1.6 Health Financing

Health sector in Nigeria is under resourced due to low budgetary allocation to health, poor management and misdistribution of available resources (11). The government has not been able to provide adequate services for its population especially those in rural areas where higher rates of poverty prevail (11). The National Health Insurance Scheme (NHIS) was enacted in Nigeria in 1999 to provide universal, accessible and affordable health care to the general population but the implementation was delayed till 2005 due to lack of consensus on policy issues on whether it was going to solve the problem of health sector financing in Nigeria (13).

In spite of its implementation in 2005, the aim of establishing the NHIS has not been achieved since it has failed to cover over 70% of the population as expected, especially those in informal sector of which more than 55% of the population work (14). A review of health financing in Nigeria revealed high out-of-pocket expenditure by individuals on health whilst subscription to any form of health insurance has been very low (15). This problem in financing the system could be attribute to the insufficient government budgetary allocation to healthcare which is analysed in detail in the next chapter (15). Figure 2 presents a schematic of the Federal government's allocation to the various ministries.

Figure 2: Schematic of budgetary allocation to selected federal ministries in Nigeria from 2015-2016



Source: ISPI (16)

CHAPTER 2: PROBLEM STATEMENT, SIGNIFICANCE AND OBJECTIVES

2.1 Introduction

This chapter begins with a description of the problem related to the current implementation of the NHIS and presents a justification for the study. The methodology and conceptual framework used for the study is also presented.

2.2 Problem Statement

Financing healthcare and the attainment of Universal Health Coverage (UHC) remain a challenge to most governments especially in low and middle income countries (17). UHC has been acknowledged by the Director General of the WHO, Margaret Chan as the "single most powerful tool that public health has to offer" (18). Attaining UHC encompasses a range of complex processes and interventions aimed at ensuring that all individuals in the country have access to affordable and quality healthcare of sufficient quality without suffering catastrophic expenditures (19). While the WHO recommends that everyone should have access to quality health services without suffering financial hardship, high cost of healthcare plays a significant role in the attainment of UHC (17).

Nigeria adopted the National Health Insurance Scheme (NHIS) in 2005 which aims to provide access to quality and affordable health care for all Nigerians regardless of whether they access health care in the public or private health sector (13). This was to assist in the achievement of UHC. However, the level of coverage as well as access to essential services in Nigeria is still unacceptable (15). Among pregnant women attending antenatal care (ANC), coverage for women making 1st and 4⁺ visits according to the 2013 DHS is 34.2% and 51.1% respectively, 38.1% of deliveries are assisted by skilled birth attendants (SBA) (2). An estimated 3.3 million Nigerians are infected with HIV whilst there is minimal access to prevention, care, and treatment (20,21). Whilst there has been no or little reduction in HIV related deaths since 2005; more than 50% of people living with HIV in Nigeria have no access to anti-retroviral therapy (21). Nigeria has a disproportionate share of global burden of disease; Nigeria represents just 2% of the world population yet the country accounted for 13% of the under-five mortality globally in 2014 (22).

The NHIS was structured to cover the formal sector, the informal sector and the vulnerable groups (23). Although, the NHIS outlined measures to ensure that all Nigerians are covered under the NHIS; less than 5% of the population is presently covered by the scheme (15,24). Inadequate mechanism of pooling resources and the vast population of the informal sector makes it difficult for effective implementation of NHIS (25).

As a result, many poor Nigerians who face financial hardships are unable to access quality healthcare services when they are sick (25).

Challenges to the development of health in Nigeria include insufficient and uneven distribution of human resource for health, inadequate and ill equipped government health facilities and low remunerations (12). These coupled with poor leadership and management have been the basis for unsuccessful implementation of most health policies and programmes on health care delivery including NHIS (12,15). Despite the implementation of the NHIS, out-of-pocket expenditure as percentage of Total Health Expenditure (THE), ranged from 60% to 72% between 2005 and 2015; higher than the proposed 20% benchmark and risk for catastrophic expenditures leading to financial impoverishment (26,27). Table 2 presents an overview of health financing expenditures.

Table 2: Selected Indicators on health expenditure in Nigeria

| Indicators | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|------|------|------|------|------|------|------|------|------|------|
| Total Health Expenditure (THE) % Gross Domestic Product (GDP) | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 3 | 4 | 4 |
| General Government Health Expenditure (GGHE) as % of Total Health Expenditure | 29 | 33 | 33 | 37 | 31 | 26 | 31 | 31 | 24 | 25 |
| Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE) | 71 | 67 | 67 | 63 | 69 | 74 | 69 | 69 | 76 | 75 |
| General Government Health Expenditure (GGHE) as % of General government expenditure (GGE) | 7 | 9 | 9 | 8 | 7 | 6 | 7 | 7 | 6 | 8 |
| Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE) | 68 | 64 | 64 | 60 | 66 | 71 | 66 | 66 | 73 | 72 |
| Out of Pocket Expenditure (OOPS) as % of Private Health Expenditure (PvtHE) | 96 | 96 | 96 | 96 | 96 | 96 | 96 | 96 | 96 | 96 |
| General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

Source: Global Health Expenditure Database (27)

The general government expenditure on health (GGHE) as a percentage of the government general expenditure (GGE) is 7% compared to the recommended 15% budgetary allocation for health as required by the Abuja declaration. The total health expenditure (THE) as a percentage of GDP has consistently remained 4% over the years. Private health expenditure as a percentage of THE was 75% in 2014 (28). Given the present situation, there is an urgent need to reassess current health financing mechanisms and adopt holistic and more efficient strategies to achieve UHC. The exigency of this proposed plan cannot be overemphasized being highly conscious of the future impact of this problem in a fast growing country like Nigeria with an estimated population of more than 180 million (4).

2.3 Justification

The measures utilized by a country to finance its healthcare system has significant implications for the attainment of UHC (29). This is because it is critical in determining the coverage, availability, accessibility, affordability and quality of healthcare services for its citizens (29). NHIS as a financing option can assist in the attainment of UHC if it is well-planned and managed properly (29). At the Presidential Summit in 2014, Nigeria's President Goodluck Jonathan declared that NHIS must be compulsory to help in the attainment of UHC and reaffirmed the federal government commitment to ensuring equitable, accessible and affordable healthcare for all (30).

Nigeria, being one of the most populous nations in Africa has the potential of making its NHIS a model in Africa (24). While expenditure on healthcare in general has been low, the fact that maternal, infant, child mortality and HIV and AIDS responses have not yielded the desired outcomes indicate the need to explore the possibilities of improving health insurance coverage to ease the financial burden associated with healthcare (24).

However, inadequate budgetary allocations for health and inadequate mechanism of pooling financial resources and purchasing health services makes it difficult to effectively increase resources for the health sector either through taxes, insurance or both (31,32). These make the attainment of universal health coverage a challenge to the health sector in Nigeria; hence the need to conduct a study on increasing UHC through health insurance scheme. This will lay bare evidence informed options that can be used to improve NHIS coverage; necessary for the attainment of UHC.

2.4 General Objective

To review the national health insurance scheme in Nigeria and compare its functionalities to neighbouring countries in order to make recommendations to help achieve universal health coverage through an effective health insurance scheme.

2.4.1 Specific objectives

1. To provide an overview of financing health care in Nigeria. (Resource generation, pooling, and Resource allocation/allocation)
2. To discuss the problems associated with achieving universal health coverage through the National Health Insurance Scheme in Nigeria.
3. To review policies and strategies adopted by the government to address the problems affecting the implementation of national health insurance.
4. To review best practices in attaining universal health coverage via benchmarking with neighbouring countries experience and summarize lessons learned from their experience.
5. To make recommendations to policy makers on strengthening the policy on health insurance in order to achieve universal health coverage.

2.5 Methodology

This study is a descriptive literature review of available published data on health insurance as a means of attaining UHC. Available reports on establishment and implementation of the NHIS in Nigeria were compared with other similar middle-income countries like Ghana and Rwanda. The OASIS approach (33,34), developed by WHO department of health system financing, was used to assess the funding and progress of health insurance scheme in Nigeria. This approach offered a better platform to discuss ways of attaining universal health coverage in Nigeria with financial risk protection.

2.5.1 Search Strategy

Literature on the subject were searched using VU e-library, Pub Med and Google Scholar to obtain published articles. To identify further potentially relevant studies missed by the electronic database search, reference lists from identified review articles were manually screened.

Specific databases of relevant agencies such as The World Bank, World Health Organization, Nigerian Ministry of Health and NHIS website were all reviewed to obtain policies, programme reports and fact sheets. Only studies conducted in the English language were selected for this review. No time limit was

2.5.2 Inclusion Criteria

Articles that met the following criteria were included in the study

- Article was written in the English Language
- Full text article was available

- Article reported findings on the implementation of health financing or health insurance and its effectiveness

2.3.3 Keywords

The following keywords were used in the search for literature. National Health Insurance Scheme, Universal Health Coverage, Nigeria, Out-of-pocket-expenditure were used to perform an initial broad search in different combinations. Further search was conducted using keywords related to each specific objective. Table 3 presents keywords and their combinations used to search for literature for each specific objective.

Table 3: Search Table

| No | Sources | Objective 1 | Objective 2 | Objective 3 | Objective 4 |
|----|-------------------------------------|---|--|--|--|
| 1 | PubMed and VU e-library | Resource Funding, revenue pooling, Health insurance coverage in Nigeria, collection, pooling , allocation | Challenges, gaps, government funding, donor funding, Human resource for health, | National policy, Government revenue, sources of funding, | Effectiveness of Ghana's health insurance scheme, Review of Ghana's health insurance scheme, review of Rwanda |
| 2 | National and International websites | Nigeria's Health Insurance scheme, Health care financing, Health insurance Act, Resource allocation, | Abuja declaration, Government spending, National Health Account, population coverage, Equity in financing, | Evidence based interventions, health reforms, best practices, stewardship, | Rwanda's health insurance scheme, Ghana's health insurance scheme, financing mechanism, sources of funding, benefit package of NHIS in Ghana |
| 3 | Grey Literature | HIV and AIDS, Malaria Framework, WHO building blocks, | Administrative efficiency, level of funding, improved health outcome, | Catastrophic expenditure, health care financing mechanism, national health insurance policy, | Best practices, resources allocation, financial performance, sustaining health insurance financing, |

2.5.3 Conceptual framework

For this review, three conceptual frameworks on health financing; Kutzin 2008 (35), Hsiao, 2003 (36) and OASIS, 2010 (33) were searched and compared. The two frameworks by Kutzin, 2008 and Hsiao 2003 used the same basic structure with many similarities which attempt to provide guidance for policy by identifying the links between particular health system function, financing function and system outcome (35,36). The WHO OASIS framework identifies the health financing system as one of the building blocks and stipulates that health financing is not functional if it does not provide enough funds for the health system in order to provide effective care with financial protection

(33,34). The OASIS analytical framework was chosen because it is not country specific hence it can be applied in a flexible way to provide practical guidelines to identify the pros and cons of health financing system in a country (34). It also provides recommendations to improve strategy towards achieving UHC which is the main aim of health insurance (34).

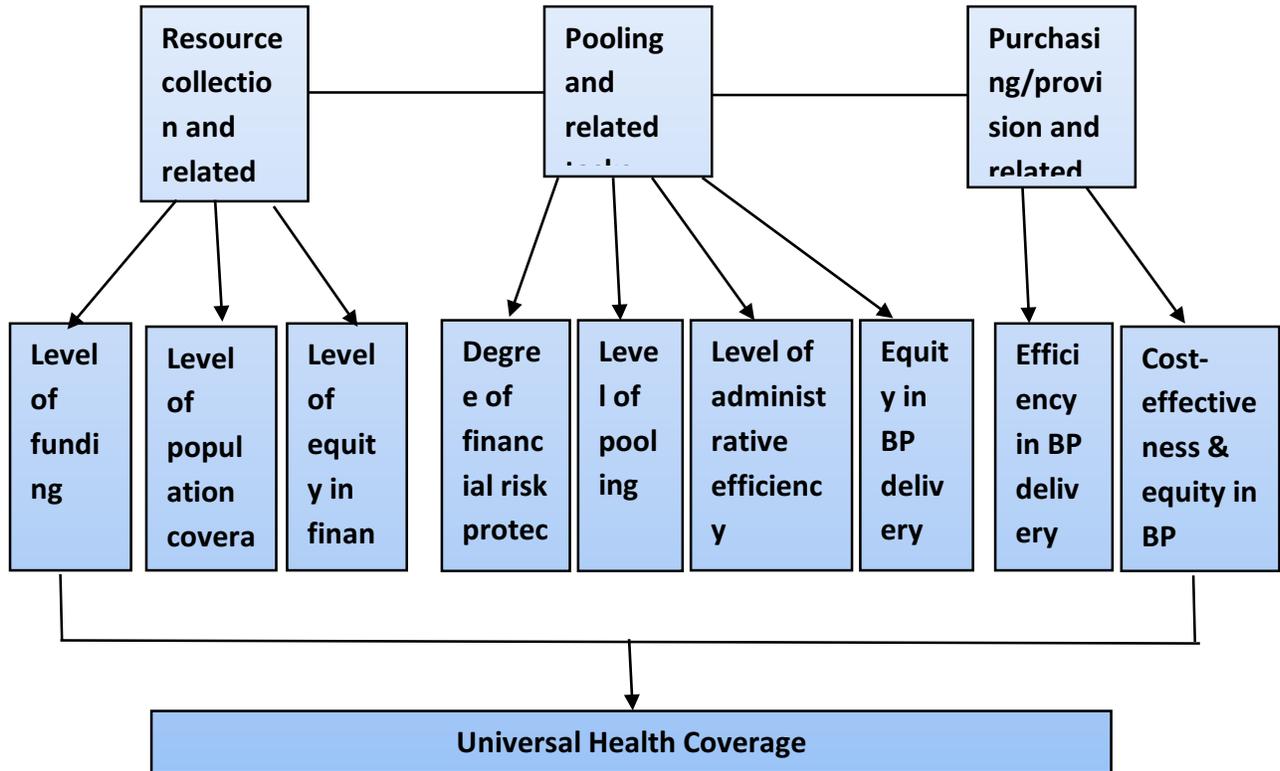
This framework reviews the stewardship and the three health financing functions of collecting, pooling, and purchasing including resource allocation (33). OASIS approach focuses on both institutional and organizational practice of the health financing system which are the distinctive characteristics of this approach (34). The main goals of OASIS analytical approach are to review health financing systems; analyse their strengths and weaknesses; understand the six types of bottlenecks in institutional design and organization practice which are the causes of inadequate performance and use health financing performance indicators to assess the performance of a health financing system and specific schemes (33,34).

The health financing performance is further operationalized to nine indicators which include:

- Level of funding.
- Level of population coverage.
- Level of pooling across the health financing system.
- Level of equity in health financing.
- Level of financial risk protections.
- Level of operational efficiency
- Level of equity in the delivery of a given basic package.
- Level of administration efficiency.
- Degree of cost effectiveness and equity considerations in benefits package definition

This approach was used to assess the progress of health insurance as a mechanism towards achieving universal health coverage in Nigeria. Figure 3 presents the modified framework used in the study.

Figure 3: Modified OASIS Framework for the study



Source: WHO (33)

2.5.4 Limitations of the study

Only literature published in the English language was used in this study. As a result the study may have excluded articles published in different languages. Official statistics about the utilization of the NHIS were not available on many government websites. Some of those available reported different statistics which made it difficult to harmonize the statistics.

CHAPTER THREE: UNIVERSAL HEALTH COVERAGE IN NIGERIA AND THE NATIONAL HEALTH INSURANCE SCHEME

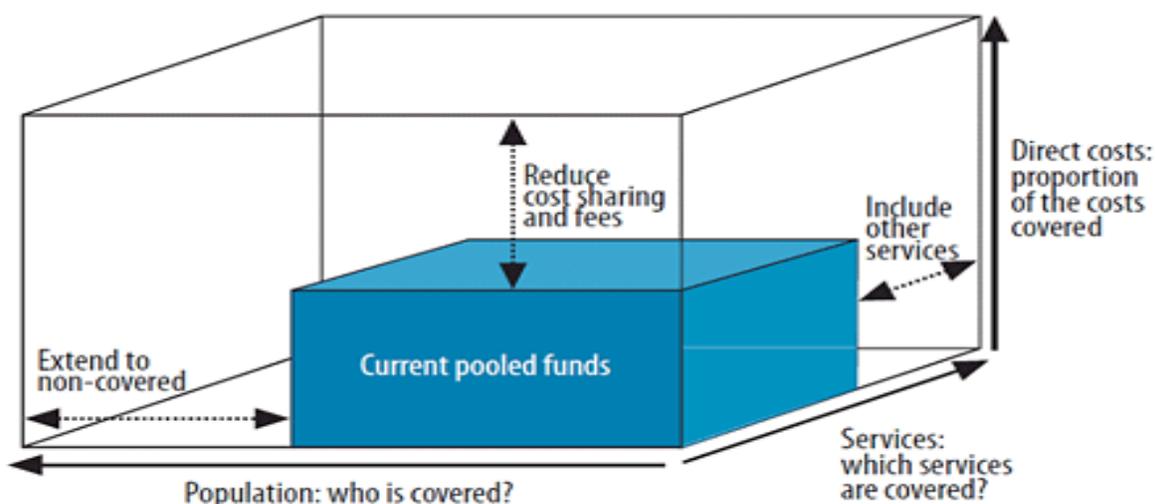
This chapter introduces the concept of universal coverage and provides an overview of health financing in Nigeria. The challenges associated with the NHIS in Nigeria is presented in accordance with the framework. The last part of the chapter deals with the strategies that have been adopted by Nigeria to manage identified challenges.

3.1 Health Financing and Universal Health Coverage

According to WHO, Health financing is one of the six building blocks of a functional health system (37). It involves collection of revenue from primary and secondary sources, direct taxes, donor funding and voluntary or mandatory prepayments; pooling resources together and purchasing of health services (37). Different resource allocation and/or strategic contractual arrangements, with mixes of provider payment mechanisms e.g., fee for service, capitation, budgeting and salaries are often used (38,39).

UHC denotes the idea that all persons who need health services should access them without suffering financial hardship (40). Attaining universal health coverage (UHC) encompasses a range of complex strategies. It is a political process that involves negotiation between stakeholders and goes beyond the health sector (40). With the addition of UHC as part of the health-related Sustainable Development Goals (SDGs), provision of funds to reach UHC has become a matter of global policy debate (41). The mechanisms by which a country is able to finance its healthcare system determines the possibility of reaching UHC (40). The level of funding influences the existence, affordability and availability of health services (42). To achieve universal health coverage UHC, the WHO recommends financing health system based pooled funds and risk sharing instead of OOP (37). The recommendation is based on study findings that financing 80% of THE with pooled funds protects the population against the risk of catastrophic expenditure and poverty while reducing the risk of moral hazard (43). As figure 2 below shows, to achieve UHC, pooled funds can be used to increase population coverage; add more services; and/or to decrease any cost sharing and fees. The rationing of pooled funds often depend on the local context (37).

Figure 4: The UHC cube: 3 dimensions to consider when moving towards UHC

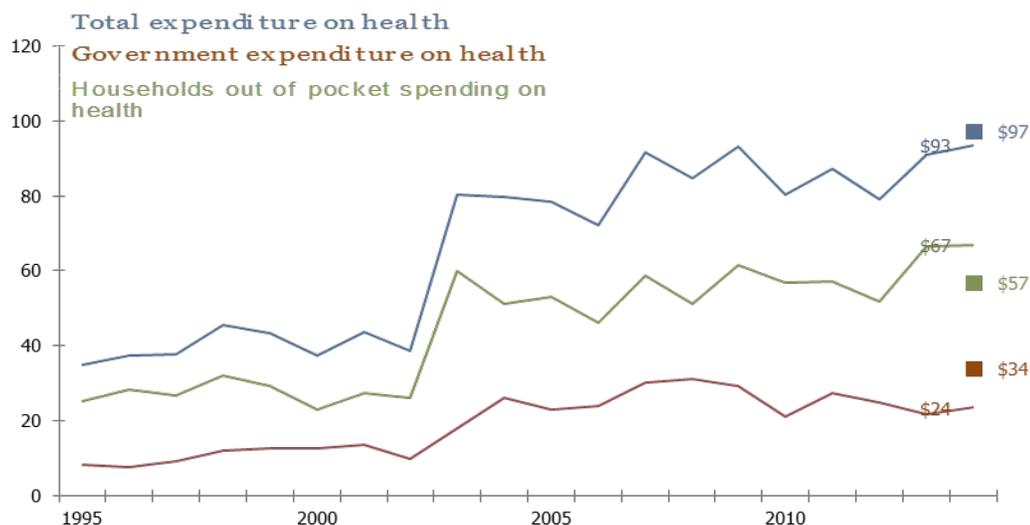


Source: Adapted from WHO (37)

3.2 Overview of healthcare financing in Nigeria

Healthcare in Nigeria is financed by a combination of tax revenue, OOP, donor funding, and SHI and CBHI (15). Choku & Okoli reports that, most federal states spend less than 5% of their total expenditure on healthcare (44). Expenditure from all tiers of government amount to less than 6% of total government expenditure and less than 25% of total health spending in the country (44). The private expenditure account for the remaining 75% of health spending, with 90% of this coming from household out-of-pocket expenditures (World Bank, 2011, cited in Choku & Okoli (44)). In Figure 3 below, the per capita health expenditure, has been rising since 1995, but much of the burden is carried by households (27). In 2013 for example, although government expenditure on health per capital was US\$23, OOP and THE were US\$67 (45). Moreover, finances are disproportionately distributed across the country with the rural poor bearing the most OOP (46). The prohibitive cost of health services and the lack of effective risk protection mechanisms such as fee exemptions and health insurance, limits health service accesibility to many Nigerians (47).

Figure 5: Nigeria’s Per capita expenditure in US\$ (2014)



Source: WHO (27).

Note: WHO aggregates are calculated using absolute amounts in national currency units converted to Purchasing Power Parity (PPP) equivalents.

Stewardship and good governance are necessary to establish sufficient, equitable and efficient revenue collection, pooling of funds to ensure financial accessibility, and efficiency and equity in purchasing/provision of services (48). The development of health financing policies that guide the functions of collection, pooling and purchasing cannot be separated from the context of a government’s available fiscal space of about 35% and the fiscal space for health (according to the Abuja commitment) of 15% (49,50).

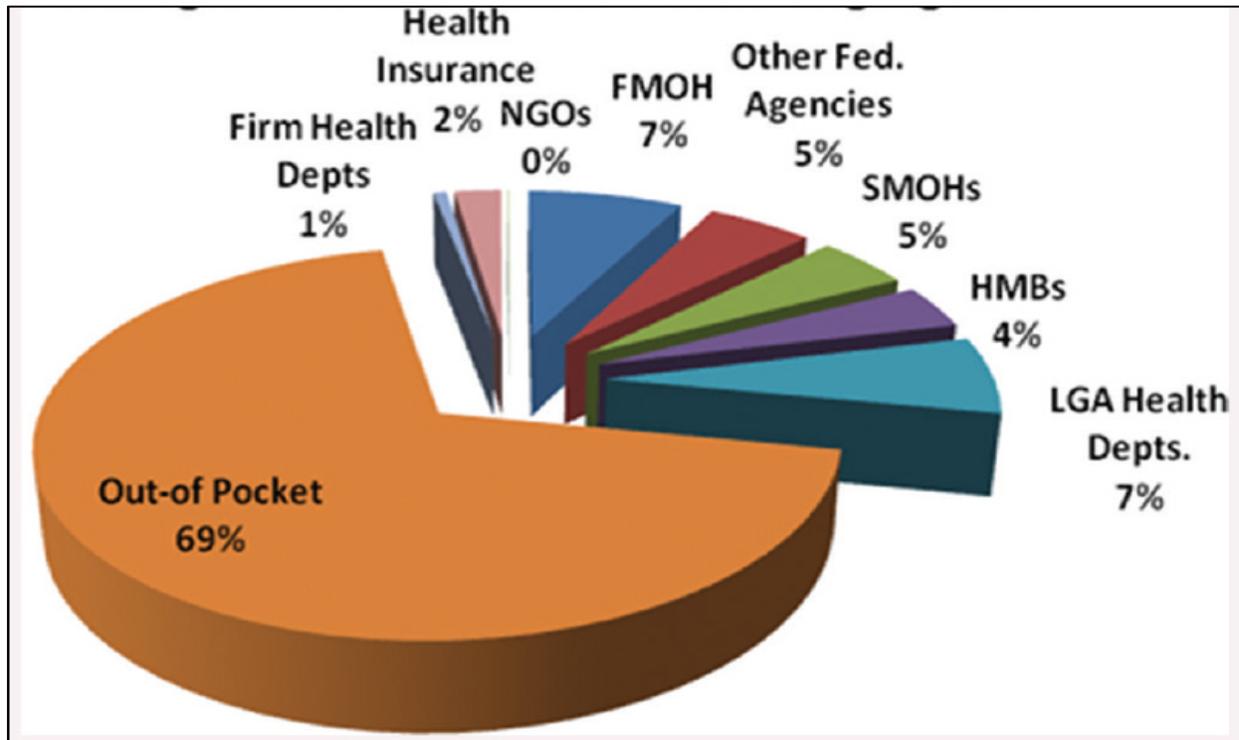
Achieving UHC may be a long-term goal for Nigeria, but it requires a well-defined strategy which must be outlined from the onset (14). This includes boosting the fiscal space for health through domestic resource mobilization; increasing official development assistance focusing on social protection schemes such as health insurance; and improving financial management of public expenditure (1).

3.2.1 Sources of funds for healthcare in Nigeria

The largest source of healthcare financing in Nigeria is OOP, which was estimated at 72% in 2014 (27). Nigeria’s national health account (NHA) show that in 2014, the private and general government expenditure on health as a percentage of THE was 75% and 25% respectively (27). External resources for health was 4% of THE, while Out-of-pocket expenditures constituted 96% of private health expenditure (27). The figure 4 below, Uzochuku et al., show

that household OOP still dominates the average federal expenditure between 2003 and 2016 (15).

Figure 6. Funding sources for Health in Nigeria



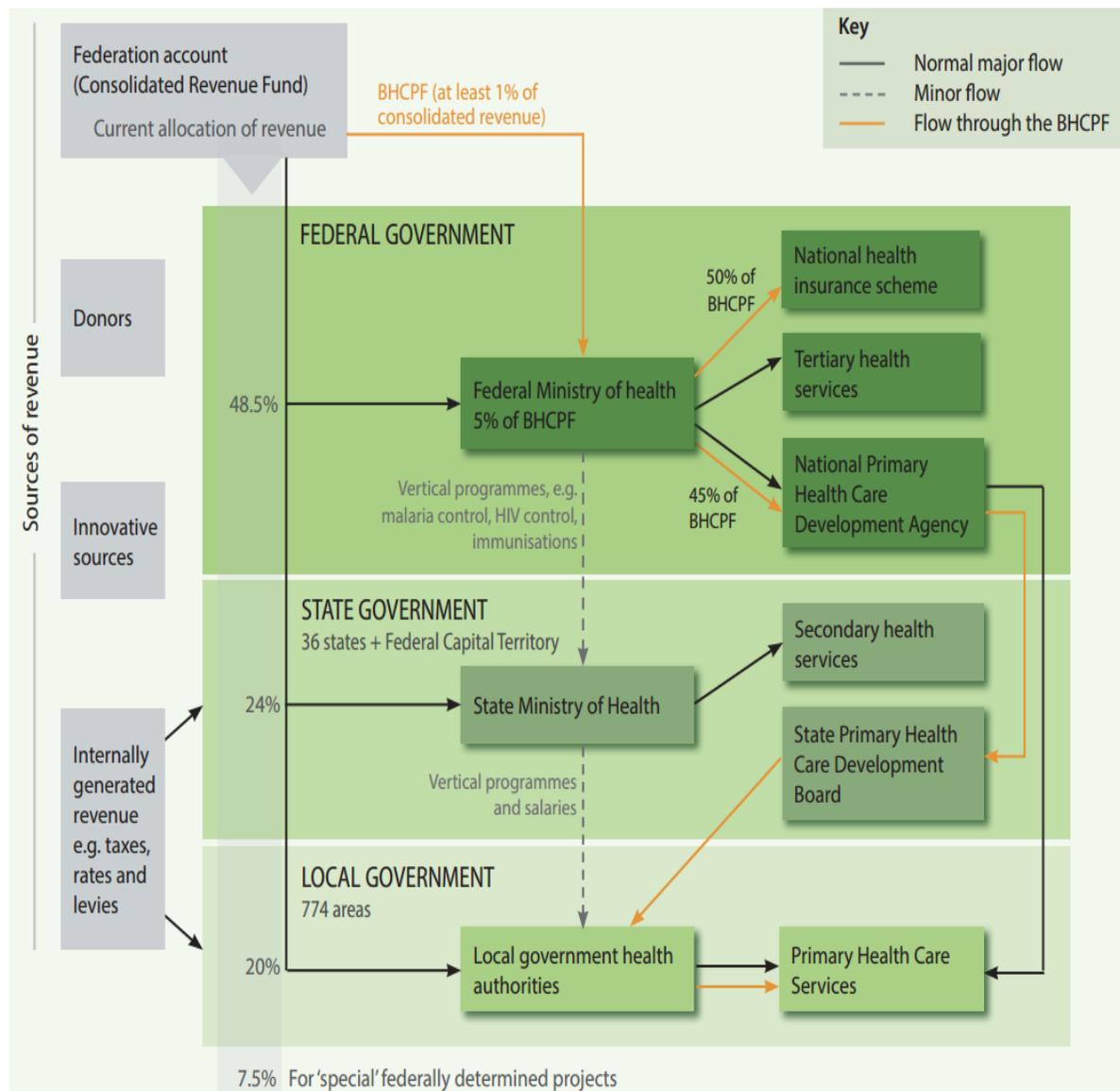
Source: Uzochukwu et al, 2015 (15)

3.2.2 Health Financing Functions

Revenue collection

Funds for financing health sector in Nigeria are usually generated through taxation or other government revenues, donor funding and OOPs (15). Revenues are raised at the federal, state, or local government levels. However, the federally generated revenues which is shared according to a formula and forms the majority of the funds for the other tiers of government (51). Funding for health related expenses in Nigeria is low mainly due to limited tax-based health financing (52). The Nigerian government enacted the 2014 National Health Act to achieve substantial increase in revenue contribution and improve primary healthcare services through the Basic Health Care Provision Fund (53). However, there is need for accountability between stakeholders at different levels of government to ensure the flow of revenue to primary healthcare centres (54).

Figure 7. Flows of funds for health services



Source: Uzochukwu, 2015 (54)

3.1.1.1 Government budget allocation

The states and local governments being closer to PHC are expected to provide adequate funding for PHC, but owing to their low internal revenue generation capacities, most of them still largely depend on the allocation from the federal government. The federal allocations to the states and local governments are not earmarked neither are the states and local governments required to

provide budget and expenditure reports to the federal government (55) .By implication, the federal government does not have a substantial control on funds allocated for both secondary and primary health services.

The general government health expenditure as percentage of THE was estimated as 25% in 2014 NHA (56) the federal government budget on health in 2016 was 4.23% of the total budget as against 5.78 in 2015 (57).

Nevertheless, the budgetary allocation for health is still below the 15% signed by the Nigerian government in the Abuja declaration. It is as low as 2% in Ondo and as high as 15% in Bauchi State (58) Given this level of government spending, it will be very difficult to provide the essential health care services, and with the fall of the oil prices in the world market, health care will always be at the problem of underfunding by the Nigerian government.

Out-of-pocket payments

OOPs involves payment for healthcare at the point of service and has remained the dominant source of healthcare finance in Nigeria, with high risk of catastrophe expenditure by households (59) . Between 2005 and 2014, OOP account for between 60% and 73% of Nigeria's THE . OOP as percentage of THE rose from 66% in 2011 to 73% in 2014 (60). In the past 10 years (2005-2014), OOP has remained 96% of private health expenditure (60).

User fee was introduced by the Nigerian government in 1998 under the Bamako Initiative which advocated for cost sharing and community participation to increase the sustainability and quality of healthcare (61). It was proposed that user fee will increase the resources available for healthcare

and improve efficiency as well as equity to healthcare (62). The available evidence on the negative impact of user fees has attracted different opinions from scholars. However, there is lack of information on the effect of user fees on revenue generation, healthcare seeking behavior, access to care, efficiency, and utilization of services in Nigeria (15). Lagarde and Plamaer, (2008) found that without accompanying visible quality improvement, user fees will result in lower utilisation of healthcare services (63). Uneke et al. (2008) also reported that majority of study participants would prefer paying user fees if they are affordable and would guarantee efficient and quality service (64).

Donor funding

This refers to financial assistance given to developing countries to support socioeconomic and its health development that may be in form of loan or grant (15). Financial assistance to Nigeria has been declining since 1999 (60). The annual average official development assistance (ODA) inflow in Nigeria reduced from USD 2.0 billion in 2010 to USD 1.8 in 2011 (65). Although the international assistance to the Nigerian health sector is decreasing, it still accounts for a small proportion of public health expenditures (65). The major challenges in Nigeria with donor funding are effective coordination of the funds and tracking donor resource flow (65). The National Planning Commission coordinates the use of financial assistance to Nigeria. At the state and local government levels, the State Planning Commission or State Ministry of Finance coordinates the use of financial assistance and provides a link between the LGAs and the federal government (66). The states vary in their capacities to effectively coordinate development aid. Other challenges with donor funding in Nigeria include the following: high cost of technical assistance, donor-driven approach to aid delivery, proliferation of aid agencies, uneven spread of donors' activities, institutional weaknesses, and problem of counterpart funding (66).

The subject of aid effectiveness has largely been debated and its macroeconomic impact has also raised concerns, (67,68).

Social health insurance

Social Health Insurance Social Health Insurance (SHI) is a system of financing healthcare through contributions to an insurance fund that operates within a tight framework of government regulations (69). It is a form of mandatory insurance scheme (normally on a national scale). It provides a pool of funds to cover the cost of healthcare and it also has a social equity function which eliminates barriers to obtaining healthcare services at the time of need especially for the vulnerable groups (69,70). In SHI while every citizen is required to make contributions, governments may contribute on behalf of the

poorest and the unemployed; employers also usually contribute on behalf of their employees (69,71).

The Nigerian government established the National Health Insurance Scheme (NHIS) under Act 35 of 1999 with the aim of improving access to healthcare and reducing the financial burden of out-of-pocket payment for healthcare services (13). The NHIS became fully operational in 2005. The NHIS is organized into the following social health insurance programmes (SHIPs): Formal Sector; Urban Self-employed; Rural Community; Children Under-Five; Permanently Disabled Persons; Prison Inmates; Tertiary Institutions and Voluntary Participants; and Armed Forces, Police and other Uniformed Services. It is only the formal sector SHIP that is currently operational (72). Membership with the formal sector SHIP is mandatory for federal government employees and about 90% coverage has been achieved. The formal sector SHIP is presently extending to include all state and local government employees with Bauchi and Cross River having achieved full coverage (72). There has been a lag in the expansion of NHIS to achieve a considerable population coverage since its inception. This has attracted a lot of criticism since many people are left out and not benefiting from it. The act that set up the NHIS makes it optional, and this has been pointed out to be one of the reasons many Nigerians are not benefiting from it (72).

The NHIS is focused on making the scheme mandatory for every Nigerian and aims to get every Nigerian enlisted before December 2015 but the goal wasn't reached (72). Other factors such as poor medical facilities, shortage of medical personal, lack of awareness, and poor funding have been identified as challenges that affect the effective implementation of NHIS in Nigeria. Various stakeholders have also raised issues about the potential mismanagement and bureaucracy that may affect the scheme (72).

3.3 Pooling arrangements

The best way to expand coverage is the establishment of compulsory prepayment of some type – e.g. taxes and other government charges, social insurance premiums – that are subsequently pooled to spread risks (43). Pooling is essentially the accumulation and management of prepaid healthcare revenue on trust for the population, ensuring that the cost of healthcare is distributed among all the members of the pool (73). The Nigerian NHIS organizes risk pooling under three main programs. The Formal Sector Social Health Insurance Program (FSSHIP) is available to public employees and the organized private sector, and is implemented via a managed care model funded through percentage contributions from employers and employees. NHIS pools funds at the federal level, and allocates them to health

maintenance organizations (HMOs) to make capitation payments and reimbursements to providers on behalf of beneficiaries allocated to HMOs (74). Only few states have adopted the program despite sustained advocacy by the NHIS and HMOs. Only 4% of the entire population is covered by FSSHIP (74).

The two other proposed schemes, the Urban Self-Employed Social Health Insurance Program (USSHIP) and The Rural Community Social Health Insurance Program (RCSHIP) are designed to serve the informal sector (almost 70% of the population) and are non-profit, voluntary schemes based on the CBHI model (74). Revenue is supposed to be generated for the USSHIP by flat-rate monthly payments with contributions dependent on the health package chosen, whereas RCSHIP members are to get accreditation according to their health needs and then choose benefits, with cash contributions being made as flat-rate monthly payments or in instalments. Health care providers offering services to the scheme members will be paid in the form of salaries. In spite of poor enrolment in all the three programs, various CBHI pilots have shown promising increases in access and healthcare utilization (74).

3.4 Health Services Purchasing

States generate taxes through internally-generated revenue, and state allocations to health are used by the State Ministry of Health (SMoH) to purchase health services for citizens (75). State-level pools are used, along with contributions from the national pool, for publicly-financed services. The entire population is covered using state level government budgets, and the SMoHs act as purchasing organizations to allocate budgets for providers at health facilities. Funds are transferred to health facilities mostly in the form of commodities and global budgets (75). The states and local governments being closer to PHC are expected to provide adequate funding for PHC, but owing to their low internal revenue generation capacities, most of them still largely depend on the allocation from the federal government (75). The federal allocations to the states and local governments are not earmarked neither are the states and local governments required to provide budget and expenditure reports to the federal government (13). By implication, the federal government does not have a substantial control on funds allocated for both secondary and primary health services.

3.4.1 Purchasers and providers relationship

Providers are assessed by the NHIS, accredited and registered and then recommended to enrolees. Only accredited facilities are registered to provide services irrespective of their location. This does not ensure geographic equity in service provision. However, within facilities, efforts are made to provide all services within the package of care and to refer patients to appropriate services . There is no clear monitoring of the clinical aspects of provider

performance by the NHIS. However, NHIS makes the annual visit to facilities to speak directly to a sample of enrolees about once a year. While the NHIS rarely visits facilities, they more regularly check providers' accounting or financial departments - one large provider receives visits from the zonal office weekly, and from the national head office once a quarter. The transfer of funds from some HMOs to providers is problematic due to differences in payment timings; funds to HMOs come on a quarterly basis and payments to primary healthcare providers are monthly, thus giving HMOs incentives to invest money in non-health activities. As a result, funds are often not available for timely reimbursement of provider claims. In other instances, HMOs would like to ensure timely payment to providers but there are delays due to slow submission of claims forms to the HMO. Furthermore, occasionally HMOs need to verify some aspects of the claims, a process that can take months, and can also delay patient treatment. Presently, there are no regular audit systems in place to counter these delays despite the fact that regulations are in place to demand that auditing is carried out by the NHIS (75).

3.4.2 Purchaser and government relationship

The NHIS has regulatory frameworks which include accreditation, supervision, auditing of HMOs and their organizational and management structure. However, perceived political interests of the NHIS governing board, which has overall control of the scheme, hinder implementation of these regulatory frameworks. NHIS also has limited capacity to monitor the performance of HMOs and providers effectively (76). The limited transparency in business practices of HMOs, especially with regards to their private plans, undermines the capacity of NHIS to regulate them. NHIS requires the submission of data and statistics on HMO public and private plans but information from private plans is not usually made available (77). Beneficiaries of the scheme are supposed to contribute towards its operation. However, in practice enrolees do not pay their counterpart funding as stipulated in design. This is because the labour unions have prevented payment until they are confident that the funds will be safely managed. Nevertheless, the amount of funding that the scheme receives appears to be adequate, although there are concerns that the situation may change in future with increased utilization of services (77).

3.4.3 Purchasers and enrolees relationship

Staff from HMOs visit the ministries and parastatals and organize regular seminars and interactive sessions to discuss the schemes' benefits package, rights, and privileges with new and existing enrolees. During these sessions, they also inform enrolees about what facilities are available to enable them to decide how to choose as a provider. However, inadequate dissemination of information and over-reliance on face-to-face meetings create huge gaps in

educating citizens about the scheme. Initial service entitlements and benefits have been revised and updated as a result of feedback from enrollees to the HMOs and onward to the NHIS during the interactive sessions. Coverage has been extended to include fibroid operations, up to four live births and the cost of hospital investigations. HMOs are allocated federal ministries and parastatals by the NHIS - which they are mandated to cover. This constrains enrollees in exercising their choice of HMO. Many eligible and potential enrollees remain uncovered because they are skeptical about the scheme. There are good channels available for enrollees to make complaints about service provision. However, over centralization of the complaints procedure by the NHIS leads to delays. Healthcare purchasing under the FSSHIP mechanism in Nigeria is currently not strategic. There is a need for monitoring and accountability of both providers by HMOs, and HMOs by the NHIS. Efforts must be made to ensure prompt release of funds to providers by incorporating strict timelines for movement of funds and attendant sanctions for non-adherence. More still, decentralization of NHIS administration in handling complaints by beneficiaries to avoid delays and improvement in the quality of services provided will engender favourable outcomes (75).

3.5 National health insurance scheme (NHIS) in Nigeria

The Nigerian NHIS is a Social Health Insurance Programme (SHIP) which combines the principles of Socialism (being one's brother's keeper) with that of Insurance (pooling of Risks and resources) (74). It is a body corporate with perpetual succession established under Act 35 of 1999 to provide Social Health Insurance (SHI) in Nigeria whereby the Health care services of the contributors are paid for from the pool of fund contributed by participants in the Scheme. The details on how the NHIS programme work are attached in Appndix 2.

The goal of NHIS is to improve the Health status of Nigerians as a significant Co-Factor in the National Poverty Eradication Efforts.

The mission of NHIS is to undertake a government-led comprehensive Health Sector Reform aimed at strengthening the National public and private Health System to enable it deliver effective. Efficient, qualitative and affordable Health Services.

The objectives of the scheme are to:

- ensure that every Nigerian has access to good healthcare services;
- protect Families from the financial hardship of huge medical bills;
- limit the rise in the cost of healthcare services;

- ensure equitable distribution of healthcare costs among different income groups;
- ensure high standard of healthcare delivery to Nigerians;
- ensure efficiency in healthcare services;
- improve and harness private sector participation in the provision of healthcare services;
- ensure equitable distribution of health facilities within the federation;
- ensure appropriate patronage of levels of healthcare;
- ensure the availability of funds to the health sector for improved services.

3.5.1 Evolution of the NHIS in Nigeria

The Bill on NHIS was first introduced in 1962 but failed to receive parliamentary approval. The national council on health conducted a study on NHIS from 1984-1989. Based on the study's recommendations, Federal Ministry of Health was directed to start the NHIS in 1992, which was officially launched in 1997. In 1999 the NHIS laws was passed paving way for effective implementation in May 2005 (78).

3.5.2 Classification of NHIS programmes

In order to ensure that every Nigerian has access to some form of financial protection, the NHIS has developed various programmes to cover different segments of the society. The Formal sector SHIP (FSSHIP), which is currently being implemented and other planned programmes that are yet to be integrated into the main scheme are as shown in table 1 below (79).

Table 4: The FSSHIP and other SHI program in Nigeria

| Category of membership | Beneficiaries | |
|-------------------------------|--|-----------------------|
| Formal Sector | <ul style="list-style-type: none">• Public sector (Federal, State, Local Government)• Organised private sector-Workplace with minimum of 10 employee• Students of Tertiary Institutions and voluntary participants | Currently implemented |
| Informal Sector | <ul style="list-style-type: none">• Rural Community• Urban self employed | Currently implemented |
| Others | <ul style="list-style-type: none">• Diaspora family and friend• International Travel Health Insurance• Pregnant women and Orphans• Retirees and Unemployed. | planned |
| Vulnerable Group | <ul style="list-style-type: none">• Permanently disabled persons and the Age• Children under the age of 5years• Prison inmates | planned |

Source: (79)

3.5.3 Contributions and Benefit Package

Contributions are earning-related and currently stand at 15% of basic salary. Employers pay 10% while employees pay 5% of basic salary to enjoy healthcare benefit. Currently, only the employer's contribution is being implemented. The benefits for memers include free cover for a spouse and 4 biological children under the age of 18 years. Additional contributions will be required for extra dependents. The basic benefits package is shown in table 2 below (79).

Table 5: Benefit package within Nigeria’s FSSHIP

| Level of healthcare services | Benefits |
|--------------------------------------|---|
| primary healthcare services | <ul style="list-style-type: none"> i) This include Access to curative services for common ailments including consumables as outpatient care. ii) Essential drugs from NHIS accredited pharmacy providers+ provision of pharmaceutical care by the Pharmacist. Beneficiary is expected to pay 10% of the total cost of drugs (Co-payment). iii) Routine Laboratory investigations iv) Health education to prevent and control health problems such as counselling and testing for HIV/AIDS etc.+ Health Education. v) Maternal and Child care; Primary Eye care; Dental and Mental services; Accident and Emergency services. |
| Secondary healthcare services | <ul style="list-style-type: none"> i) Specialist cares for medical; surgical; Paediatric; Internal Medicine; Obstetrics and Gynaecology; Psychiatry; ENT; Ophthalmology; Management of HIV/AIDS, etc. ii) Hospitalization in a general ward for a maximum of 15days per annum iii) Physiotherapy for restorative and rehabilitative services Radiology/Medical imaging and diagnostic laboratory services iv) All prescribed pharmaceuticals from FMOH essential drug lists + Co-payment. |
| Tertiary healthcare services | <ul style="list-style-type: none"> i) All Referrals from primary and secondary healthcare levels |

Source: (79)

3.5.4 Provider Payment system

Healthcare providers under the scheme will be paid by capitation, fee-for-service per diem or case payment as shown in table 3 below.

Table 6: Payment mechanisms

| PAYMENT SYSTEM | MEANING |
|------------------------|---|
| Capitation | This is payment to a primary Health care provider by the HMOs on behalf of a contributor, for services rendered by the provider. This payment is made regularly in advance for services to be rendered irrespective of whether enrolees utilize the service or not. |
| Fee-for-service | The HMO makes this payment to non-capitation –receiving Health care provider who render services on referral from other approved providers. |
| Per diem | Per diem are payments for services and expenses per day (medical treatment, drugs, consumables, admission fees etc) during hospitalization. |
| Case payment | This method is based on a single case rather on a treatment act. A provider gets paid for every case handled to the end. |

Source: (79)

3.6 Challenges of the NHIS based on the nine performance indicators to assess the NHIS

3.6.1 Level of funding

The NHIS in Nigeria is a form of SHI that is funded by both employees and employers. The employer contributes 10% while the employee contributes 5%. The NHIS is yet to be incorporate into the state funded SHI as proposed 5 years ago (80). The current policy makes contribution to the NHIS voluntary, which allows most employer to avoid payments thus weakening the scheme's financial solvency. Nigeria is yet to adopt other additional methods of funding the NHIS such as sin taxes (on alcohol and Tobacco), phone taxes, among others that have been used in other countries like Ghana. The limited funding sources for the scheme contributes to the low level of healthcare funding (2% of THE) (81).

3.6.2 Level of population coverage

Although the scheme has been operational for 11 years, it covers less than 5% of Nigeria's population. Majority of the population covered are working in the formal sector (federal government worker) who are enrolled into the SHI. The remaining form of scheme covers just about 1% of the population especially, the informal sectors workers. This low population coverage makes it far from being used as a means of achieving UHC (45,82).

3.6.3 Level of equity in health financing

Majority of Nigerians (70%) are working with the informal sector and more than 70% of Nigerians live below \$1 per day. The relatively wealthy formal workers and their families are covered but the poor and those near the poverty line are excluded from the scheme. That forces the poor to pay for health services OOP, which creates inequity in access to health services and puts them at risk of catastrophic expenditure. Unlike the formal sector, there is no reliable data collection system for the informal sector, which makes taxation of income difficult (26).

3.6.4 Level of pooling

NHIS level of pooling is limited to the contributions from the formal sector, which is inadequate to extend coverage to the poor in society. The funds are centrally managed by the headquarters, but the HMOs are in-charge of purchasing services from the HCP as the funds are released to them every 2 months. The challenge has been the inability of government to generate funds from the large informal sector and other additional sources (13).

3.6.5 Level of administrative efficiency

According to the appropriation act (2016) the total amount of money released for overhead cost is about 4% of the total amount (83). In Ghana, overhead expenses in 2013 was about 19% of total expenditure (84). This presupposes that Nigeria's scheme might be more efficient or that it is likely to overspend its overhead budget line as it appears to be the case in Ghana (84).

3.6.6 Level of Operational efficiency

The NHIS oversees the activities of the HMOs and the HCPs who provide services to those that register with the scheme. Currently, NHIS is controlled centrally by the national headquarters and assisted with the regional offices. The regional office has limited or no power to make any major change to revenue mobilisation and expenditure since the headquarters retain all authority. Communications of information is impeded within the NHIS since HMIS is not effective within the health system (79).

3.6.7 Level of equity in the delivery of a given basic package

The NHIS benefit package is the same for every enrollee irrespective of the social class of the enrollee. It covers preventive services, curative care and emergency services, health promotion activities, out and in patient care. It does not cover conditions covered by donors like HIV/AIDS, TB and leprosy; or other tertiary care such as treatments for cancer of any form, kidney failure, infertility, cosmetic procedures but covers opportunistic diseases that might result from these diseases. It also exempts enrollees less than 3 months into the scheme (79).

3.6.8 Degree of financial risk protection

The NHIS policy gives financial protections to valid membership card holders and reimburses service providers who are registered with the HMOs. However, the low population coverage of the scheme also contributes to increase OOP which has a negative impact of catastrophic expenditure and deprived most of quality healthcare when need (59). The conditions under the benefit package are almost the same as Ghana, which cover over 90% of common disease (85).

3.7 Strategies to upscale the NHIS in Nigeria

3.7.1 Community-based health insurance

Community-Based Health Insurance Community-Based Health Insurance (CBHI) is a form of private health insurance whereby individuals, families, or community groups finance or co-finance costs of health services (25). Unlike SHI, private health insurance is often voluntary compared. CBHI is designed for people living in the rural area and people in the informal sector who cannot get adequate public, private, or employer-sponsored insurance (32). It usually involves some form of community involvement in their management. The effects of CBHI on equity, the quality, and efficiency health services are still ambiguous. It has been shown that even when charges are small, the very poor are unable to enroll (86). Thus, the existing inequalities may be worsened, since the less poor people are more likely to enroll and have improved access to care and financial protection. In Nigeria, CBHI is used to cover people employed in the informal sector or living in the rural areas (25). CBHI was piloted and introduced in Anambra state in 2003, but has since remained dormant due to low prioritisation by government (74,87). A study that evaluated the impact of the Anambra community healthcare financing scheme in one of the communities on maternal health services reported that the scheme was highly accepted and it provided adequate funds for maternal health services for a great proportion of the rural communities (87). CBHI has also been introduced in Lagos and Kwara state (88). Designing, implementing,

managing, and especially sustaining CBHI requires a strong intuitional capacity, technical expertise, and management skills, which are lacking in Nigeria. These challenges limit the success of the scheme in Nigeria. Low enrolment rates greatly undermine the sustainability of CBHI (89). It is an important limiting factor and it has been reported in studies that evaluated willingness to pay for CBHI. Enrolment is affected by factors such as trust by the community in the organizer or manager of the scheme, attractiveness of the benefit package, affordability of the premium, and the quality of the healthcare (61). To improve enrolment in Nigeria, the adoption of a sliding scale of premiums, such that financial contributions are set according to ability to pay has been suggested (90) . Atugbe et al. also reported that if varied forms of payment are allowed, such that households can choose to make contributions in whatever forms of payment they could afford, enrolment rate will be increased (89). There is also need for awareness-raising, essentially in the rural areas and finally, government funding support has also been advocated to ensure the financial viability of CBHI in Nigeria. 19

3.7.2 Private Insurance

Private health insurance (PHI) is directly and voluntarily funded by prepayment by the insured members. In Nigeria, an estimated 1 million people are covered in the PHI and this is <1% of the population. This is when employees of an establishment receive medical care from stipulated health facilities at a cost to the employers.(24) Coverage by private health insurance is scanty and is almost totally restricted to employees and their dependents. The health benefit packages of PHI varies and are usually determined by the employers and private healthcare market. However, on the average it covers the cost of registration, outpatient consultation, Immunization, antenatal care, normal delivery, simple dental services, minor surgeries and sometimes, major surgeries (91) .

3.7.3 National PHC Development Fund

PHC is the cornerstone of the Nigerian health system. However, it has under functioned in the last decades with concomitant consequence on the overall performance of the health system. (92) Poor financing is a well-known problem of PHC in Nigeria. (93).Thus, addressing the perennial underfunding that has affected PHC is high on the policy agenda. NPHCDF is a pool of fund set aside for primary healthcare , with guidelines on how the funds should be allocated. The fund aims to pool resources from the government, international donor, and private sectors. The fund is reserved for provision of basic minimum package of health services through the NHIS (50%); provision of essential drugs for primary healthcare (25%); the provision and maintenance of facilities, equipment, and transport (15%); and development of Human

Resources for Primary Health Care (10%) 95. It will be disbursed by the NPHCDA through state primary healthcare boards for distribution to local government health authorities on the basis of commitment and adherence to the provision of the act that set up the development fund (94). NPHCDF if established would liberate PHC from the recurrent problem of underfunding and consolidate the efforts toward improving healthcare services in Nigeria. This fund should also improve the public– private partnerships to mobilize funds for healthcare in Nigeria. With the establishment of the fund, foreign aids could be paid into this fund and disbursed centrally thus addressing issue of national priority in contrast to the current situation where the three tiers of government get grants independently from foreign donor for different priorities that do not align with national priorities (68).

3.8 Insurance schemes and strategies adopted Nigeria

Policies and plans set up for the financing of health in Nigeria

Nigerian government has adopted different strategies towards improving healthcare financing. These policies and plans incorporate the National Health Policy, Health Financing Policy, National Health Bill and National Strategic Health Development Plan (95)

3.8.1 National Health Policy

The major pushes of the National Health Policy in connection with health financing are to expand financial possibilities for healthcare services. It likewise tries to connect with groups and families in community-based plans for funding of primary consideration services. Open private organizations are similarly introduced as basic approaches to the development of health financing choices at all operational levels. (96) Specific procurements incorporate expanding government funding to international measurements, prioritization of primary healthcare and Provincial poor in funds allocation and redistributing so as to develop allocative proficiency asset assignment between levels of consideration to guarantee good distribution to preventive and promotive factor (97,98).

3.8.2 National Health Financing Policy

The Federal Ministry of Health articulated a National Health Financing Policy in 2006. The policy tries to prioritize value and access to quality and moderate healthcare and to guarantee an abnormal state of proficiency and responsibility in the system through reasonable and practical financing system (Nigeria, 2006). The general objective was to ensure availability and accessibility of adequate and feasible funds for moderate, proficient, and fair healthcare procurement and utilization. The policy stipulates that "however much as could reasonably be expected, endeavours will be made to debilitate

out-of-pocket health expenditure" and enhance funding for disease-specific intercessions. At present, <5% of national spending plan goes to health and <5% of the Nigerian populace is secured by NHIS and state health insurance plan is just introduced in two states out of 42 conditions of the alliance (99).

3.8.3 National Health Bill

The National Health Bill seeks to give authoritative clarification and funding sources to strengthen primary healthcare . It incorporates procurements for a Basic Health Care Provision Fund. This bill has been passed. The Bill targets all-inclusive scope with at any fundamental rate services. Specifically, the fund is to be financed from the solidified fund of the Alliance (a sum not <1% of its worth), grants by international donor accomplices; and funds from some other source. It is suggested that:

- I. 54% of the fund should be utilized for the procurement of fundamental least bundle of health services to all residents, in qualified PHC offices through the NHIS
- II. 29% of the fund should be utilized to give critical medications to primary healthcare
- III. 18% of the fund should be utilized for the procurement and support of offices, hardware and transport for primary healthcare
- IV. 9% of the fund should be utilized for the development of HR for qualified PHC offices; and
- V. 6% of the fund should be utilized by the Federal Ministry of Health for National Health Emergency and Epidemic Response.

The Bill suggests that National Primary Health Care Development Agency has obligation regarding dispensing the funds for key medications for PHC, office support, and human asset development through State Primary Health Care Boards for circulation to Local Government Health Authorities. The Bill showed that for any state or nearby government to qualify for government square give, the state and Local Government Area must contribute not <10% and 8% individually of the total expense of the scheme. (100)

3.8.4 National Strategic Health Development Plan 2010-2015

National Strategic Health Development Plan (National Health Plan) - reflects shared interest to reinforce the national health system and to improve the health status of Nigerians. This plan encourages all performers towards delivery on a mutual results structure and to be responsible for accomplishing

the objectives as outlined in the outcome system. The health arrangement, which is an addendum to the rules of the National Planning Commission ((101). Vision 2020, serves as a reference for the health part Medium Term Sector Strategy and annual operational plans and spending plans at all levels. The general objective is to guarantee that sufficient and practical funds are accessible and given for available, reasonable, productive, and impartial healthcare procurement and utilization at the neighbourhood, state and government levels

The vital targets are:

1. To create and execute health financing strategies at government, state and neighbourhood levels reliable with the National Health Financing Policy
2. To guarantee that individuals are shielded from financial fiasco and impoverishment as an aftereffect of utilizing health services
3. To secure a level of funding expected to accomplish wanted health development objectives and destinations at all levels in a reasonable way
4. To guarantee proficiency and value in the distribution and utilization of part health assets at all levels.

Projected solutions to the barriers in the attainment of health financing goals; a means to achieving universal health coverage

- There are lots of barriers to the attainment of our financing goals and they include:
- Inadequate political commitment to health, leading to poor funding of health in general, and PHC in particular
- Gaps in the area of stewardship and governance as evidenced by lack of clarity of the role of government, at all levels in financing healthcare
- Absence of a health policy that clearly spells out how funds are to be allocated and spent in the health sector
- Governance issues with the NHIS and poor buy-in by the states limiting coverage
- Dominance of OOPs presents possibilities of under/ oversupply of services depending on financial abilities
- Non exploitation of other sources of health financing
- Several stakeholders, including development partners finance health independently and not in accordance with governments' policy thrust. This has led to inefficient use of scarce resources and duplication of efforts

Several countries have been devising innovating health financing mechanism in other to achieve UHC. These responses, which have attracted considerable controversy involve the questions of whether to pay for healthcare through general taxation or contributory insurance funds to improve financial

protection for specific sections of the population, whether to use financial incentives to increase healthcare utilization and improve healthcare quality, and whether to make use of private entities to extend the reach of the healthcare system (102). As proposed in Ghana, the introduction of a “OTPP policy” as an avenue to financial risk protection to those not employed in formal sector (103).

CHAPTER 4 REVIEW OF EXPERIENCES OF DEVELOPING COUNTRIES IMPLEMENTING A HEALTH INSURANCE SCHEME

This chapter presents an analysis of findings of two countries in Sub-Saharan Africa that have implemented their own NHIS to aid in achieving UHC. Here, the three dimensions of coverage will be analysed specifically who, what services and the costs covered by the various schemes. Ghana and Rwanda are chosen for this analysis because they have both instituted an ambitious NHIS in the past ten years and reported varying degrees of success stories. Analysing these two schemes would assist in drawing comparisons from their experiences with that of Nigeria with respect to their feasibility and applicability. Through this, lessons can be drawn on what actions Nigeria can take.

4.1 NHIS: The Case of Ghana

Ghana started its NHIS in 2003 as an aid to achieving UHC (104). The scheme evolved from an initial community-based scheme to a comprehensive national scheme with an active subscriber base of 10.5 million (105). Ghana has an extensive benefits package with 95% of all medical conditions expected to be covered by the NHIS (105). At the same time, it has broad premium exemptions with 69% of subscribers exempt from paying premiums (105). Funding for the NHIS is through an earmarked NHIS levy which 2.5% value added tax on goods and services, 2.5% Social Security contributions from formal sector workers, premium from the informal sector and donor contributions (29). As a result General Government Health Expenditure as a percentage of THE increased from 72% in 2010 to 74% in 2011. The National Health Insurance Authority has reported several success stories of increased access to health services and reduced OOPs with 29 million health facility visits by subscribers in 2014 (105).

In spite of these, there have been varying opinions as to whether the 2.5% insurance levy is actually progressive or regressive whilst the quality of health services provided to subscribers has been a major issue (29). Again, the scheme has been faced with crucial challenges with expenditure exceeding revenues and the authority unable to pay providers leading to providers withdrawing their services in certain instances (29,106). GGHE as a percentage of THE reduced to 60% in 2014. Also, analysis of the exemptions policy has shown that more than 30% of those exempt are from the highest wealth quintiles who are capable of paying premiums (29). Furthermore, NHIS subscribers in low resourced areas in Ghana are still challenged with to

services as subscription does not necessarily guarantee the availability of services (29).

The authority has started piloting a capitations policy as a response to the escalation in expenditure (106). The government at the beginning of 2016 has constituted a body to review the NHIS in Ghana (106).

The findings illustrate the fact that although Nigeria can learn from Ghana's success stories, it has to be done cautiously with reference to the challenges Ghana is currently facing; and the necessary adjustments made where necessary.

4.2 NHIS: The case of Rwanda

Rwanda's NHIS has been described as one of the success stories of countries moving towards UHC with impressive political commitment (107). Rwanda's NHIS is made up of SHI for the formal sector and military; private health insurance and mandatory CBHI for the informal sector and those in the rural areas (108). Majority of the population is covered through the CBHI. Coverage of the CBHI was estimated to have reached 92% of its population in 2011 with overall coverage of NHIS estimated at 96.15% (107,108). There has been a progressive increase in healthcare access from 31% in 2003 to 107% in 2012 almost fulfilling the WHO's target of one visit per capita per year (107).

However, the Rwandan NHIS is also faced with challenges of financial sustainability. Rwanda depends significantly on funding to finance its health sector. External resources as part of THE has remained significantly high from 2010 to 2014 and was estimated at 46% in 2014. This has implications for financial sustainability of their health financing should external funding become unavailable (108). Again an assessment of the CBHI has shown that although stratified premium was instituted to enable individuals pay according to their income categories, many Rwandans are still unable to afford premiums due to high poverty levels (107). An estimated 44.9% of Rwandans live below the poverty line with 24.1% in extreme poverty. As a result, access to healthcare for the poor in some districts is still limited (107). According to the National Health Insurance Policy, there are challenges to the sustainability CBHI schemes in poorer districts due to underfunding (108).

In spite of reported success of the CBHI in Rwanda, OOP expenditure as a percentage of THE has remained unchanged from 2010 to 2014; remaining between 28% and 29%. This indicates that the expected financial risk

protection has not been achieved with members of CBHI still bearing costs of health services (107). Rwanda also faces a similar situation to Ghana where members of CBHI schemes in poor districts may not be able to get access to needed services in spite of their membership. This is due to the unavailability of such services in their communities. Despite these, Nigeria can still draw on some elements of the Rwandan NHIS to make inputs to the Nigerian NHIS. Table presents selected indicators comparing the health financing of Ghana, Rwanda and Nigeria.

Table 7: Selected indicators to compare the National Health Accounts (NHA) of Ghana, Rwanda and Nigeria from 2010-2014

| Selected Indicators of NHA from Ghana | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|-------------|-------------|-------------|-------------|-------------|
| Total Health Expenditure (THE) % Gross Domestic Product (GDP) | 5 | 5 | 5 | 5 | 4 |
| General Government Health Expenditure (GGHE) as % of Total Health Expenditure | 72 | 74 | 66 | 70 | 60 |
| Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE) | 28 | 26 | 34 | 30 | 40 |
| External Resources on Health as % of Total Health Expenditure (THE) | 18 | 15 | 12 | 9 | 15 |
| Social Security Funds as % of General Government Health Expenditure (GGHE) | 20 | 18 | 25 | 21 | 32 |
| Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE) | 18 | 16 | 27 | 20 | 27 |
| Selected Indicators of NHA from Rwanda | 2010 | 2011 | 2012 | 2013 | 2014 |
| Total Health Expenditure (THE) % Gross Domestic Product (GDP) | 8 | 8 | 8 | 8 | 8 |
| General Government Health Expenditure (GGHE) as % of Total Health Expenditure | 37 | 36 | 37 | 38 | 38 |
| Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE) | 63 | 64 | 63 | 62 | 62 |
| External Resources on Health as % of Total Health Expenditure (THE) | 64 | 65 | 65 | 54 | 46 |
| Social Security Funds as % of General Government Health Expenditure (GGHE) | 17 | 24 | 24 | 25 | 25 |
| Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE) | 28 | 29 | 29 | 28 | 28 |
| Selected NHA Indicators from Nigeria | 2010 | 2011 | 2012 | 2013 | 2014 |
| Total Health Expenditure (THE) % Gross Domestic Product (GDP) | 3 | 4 | 3 | 4 | 4 |
| General Government Health Expenditure (GGHE) as % of Total Health Expenditure | 26 | 31 | 31 | 24 | 25 |
| Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE) | 74 | 69 | 69 | 76 | 75 |
| External Resources on Health as % of Total Health Expenditure (THE) | 8 | 5 | 6 | 5 | 7 |
| Social Security Funds as % of General Government Health Expenditure (GGHE) | - | - | - | - | - |
| Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE) | 71 | 66 | 66 | 73 | 72 |

Source: (60)

CHAPTER FIVE: DISCUSSIONS

5.1 Introduction

This chapter presents the discussion of the findings on the challenges of the NHIS in chapter three and the interventions reviewed in chapter four.

The study found that of the 9 indicators, the level of funding, the population coverage, the degree of financial risk protection, the level of pooling are inadequate to consider universal coverage. The study also found inequity in health financing and financial risk protection, and likely inefficiency in administration. The benefit package may be cost-effective and equitable in its definition. However, the delivery of the package may not be equitable. In a nutshell, the findings show that Nigeria's NHIS not yet capable of attaining universal health coverage. The review shows that a combination of interventions is necessary to increase population coverage and increase revenues, leading ultimately to UHC. But a strong political will is necessary in ensuring that the NHIS is properly implemented and effective.

5.2 Revenue collection and related tasks

With regards to the level of healthcare 2014, THE as percentage of GDP was 3.7%-4%, with public expenditures comprising 35%, that is around 1% of GDP, and this is less than recommended minimum of 5% necessary for the provision of basic health services (109). The GGHE of 25% of THE is very low, with one of the reasons being low government allocations to health (roughly 7%), much lower than the Abuja target of 15% of GGE held in Nigeria. This leaves a huge burden of 75% of total healthcare cost for private expenditure. Overall the OOP of 72% of THE nearly 4 times higher than the recommended threshold of 20% beyond which the risk of catastrophic expenditure and poverty increases. Considering the fact that Nigeria spends about 4% of GDP as THE, of which 25% is public; it means government effectively contribute only 1% of GDP, which is rather too small for universal health coverage.

Several sources of funding could help in reducing OOP including sin taxes, earmarked VAT and/or external resources. However, Nigeria being a middle income country, is unlikely to attract more foreign aid than it has now. The most sustainable and reliable source of health financing, which is also recommended by the World Health Organization, is the NHIS. But currently the NHIS is limited in funds and covers only a small fraction of Nigeria's vast population. To achieve universal coverage, the pooled funds for NHIS must increase in order to cover more vulnerable people in the society and to add more health conditions that are currently excluded. It is feasible to add an earmarked tax of 2.5% on all petroleum and some imported goods as in the case of Ghana. Moreover, there is the need to develop innovative strategies

to collect taxes from the informal sector, including sin taxes, and mobilephone taxes as is the case of Ghana.

Since OOP is regressive efforts must be put to ensure everyone is covered by the NHIS and everyone contributes according to capacity to pay.

Although experience elsewhere show that CBHI is more common with adverse selection and lack sustainability, Rwanda's success shows that CBHI is not only feasible, but can be sustainable in Nigeria. Moreover, although the small scale funding base may not provide a good basis for pooling across a large population, Ghana's experience shows that if CBHIs are properly supervised and given the necessary staff, they can grow and be merged into the main scheme. Nigeria's own experience shows that acceptability of CBHIs is high in both urban and rural areas. It is noteworthy that the NHIS alone may not achieve UHC without the support of other general revenues and donor supported programs (like HIV, ART) for which the coverage is much higher. In principle, the whole population is eligible to these schemes/funding arrangements. The main problem remains that the governments fiscal space for health is insufficient, implying some states access to services may be insufficient; besides, more public money may benefit the rich and urban elites more than the poor rural dwellers. Thus to attain UHC, more effort should be put into growing the NHIS (improving revenue collection from both formal and informal sectors).

5.3 Pooling and related tasks

The inefficient revenue collection and the low coverage all have negative impact on the amount of money available for the pool. Although expected to cover more than 60% of the target population, poor data makes it difficult to know the exact population covered. However it is plausible to assume that coverage is not as good as for the formal sector because the regulations are more difficult to enforce. Pooling of funds via payroll deductions is difficult in the large informal sector. The informal sector will likely benefit more from CBHI programmes as there is a sense of ownership of the funds. For example by organizing elections to determine who represents them in managing the funds, may improve their sense of security and their commitment to pay, the team must be supported by staff. Furthermore, community participation may be improved if the funds are domiciled within the community. It must however be clarified that this is not always the case as Nigeria itself experienced. Funds from various sources including government funds, donor contributions and flat rate contributions should be harmonized to support the CBHIs. The NHIS utilizes HMOs as health managers for paying healthcare providers, quality assurance, registration of enrollees and sensitization of participants as part of improving transparency and operational efficiency of the system. The HMOs have become more efficient with decentralized offices nationwide that carry

out the activities of each region speedily. The NHIS can learn from the operational style of the HMOs and decentralize her activities accordingly. Mainly because the NHIS is centralized, its administration is inefficient. Providers have complained of inadequacies in the provider payment systems (PPS), largely due to the fact that the fund pool is too small to cover enrollees. The pooling system of Ghana can also be adopted by Nigeria (that is cross-subsidy of the smaller schemes from the central pool funds).

5.4 Purchasing/provision of services

For the sake of sustainability, the number of services covered under the Benefit package is limited to prevent rapid depletion of the small pool of funds from the formal sector social health insurance. Regarding equity, the benefits package includes services that can benefit all the population subgroups. The services include out-patient care, prescribed drugs, pharmaceutical care and diagnostic tests on the National Essential Drugs List and Diagnostic Test Lists, maternity care for up to 4 live births, preventive care and most common health conditions. However mental health services (at the primary level), and geriatric services are excluded. The major challenges that are limiting the NHIS include inadequate funding, low population coverage especially the informal sector and vulnerable groups, inadequate financing especially for the informal sector, inadequate administrative and operational efficiency, and non-inclusion of very important services like mental health , minor cosmetic treatment like cosmetic surgery after burns and cancer treatment.

CHAPTER 6 CONCLUSION AND RECOMMENDATION

This chapter begins with a conclusion which provides a summary of this study. Thereafter, recommendations are provided based on the findings of the study.

6.1 Conclusion

An effective health financing system involves collection of revenue from primary and secondary sources including OOPs, direct taxes, donor funding and voluntary/mandatory pre-payments; pooling of these funds and purchasing of health services. Nigeria has made efforts to provide UHC for its citizens through the NHIS. However, funding for the NHIS has been insufficient resulting in less than 5% of the population being covered by the NHIS. Government's budgetary allocation for health expenditure has consistently remained low from 2010-2014; significantly less than the 15% recommended at the Abuja Summit on UHC.

The study has shown that the NHIS is challenged in raising adequate funds for its activities whilst revenue generation in the informal sector that makes up majority of Nigeria's population continues to be a challenge. It is imperative that innovative ways of generating funds to finance the scheme are developed whilst political commitment by the government in providing healthcare for its citizen's is extremely important. Furthermore, collaboration and engagement of all stakeholders including community members is essential in ensuring the success of the scheme while creating a sense of community ownership.

Nigeria can learn from the examples of other developing countries that have implemented different forms of health insurance for their populace such as Rwanda and Ghana. However, it is important to also learn from their shortfalls and challenges so that such situations do not befall the Nigerian NHIS.

UHC is achievable in Nigeria. However, good governance is required to establish sufficient and equitable revenue collection, pooling of funds to ensure financial accessibility in provision of efficient health services to the Nigerian people. The best approach for boosting the fiscal space for health system is through domestic resource mobilization, increasing official development assistance focusing on social protection schemes such as health insurance, and through improvements to the financial management of public expenditure.

6.2 Recommendation

Lack of success in achieving health care financing, has continued to be a challenge in attaining UHC in Nigeria. The NHIS if implemented effectively remains the mechanisms through which UCH will be attained and improve the health outcome in the general population. The following recommendations are

made based on the findings of the study.

6.2.1 Government, policy makers

1. The government must strengthen its commitment towards UHC by making health sector a priority area for funding. This can be achieved by increasing government's budgetary allocations to health (now around 7%) to meet the 15% Abuja declaration as agreed by the 2001 AU conference held in Nigeria.
2. Revising and enforcing the implementations of the NHIS policy to make it compulsory for all citizens like what is done Rwanda as voluntary health insurance schemes in Nigeria has proven to be unsuccessful. This would ensure that a wider pool of funds are available and risk sharing is more effectively done.
3. Increasing the pool of funds available by increasing 'sin taxes' on harmful products like alcohol, tobacco to unhealthy foods like sugar, sweet, trans fat and earmarking the revenues generated specifically to the NHIS. Through this increased the fiscal space premiums and thus adherence to the NHIS for the poor and for the informally employed can be subsidized or exempted
4. Funds can also be raised through solidarity taxes on mobile phone usage considering the large mobile phone subscriber base.
5. Ultimately, the government should work toward improving the economy of the country by increasing the GDP as this will invariably reduce poverty and improve the health status of the people.
6. Effective use of available resource should be ensured by avoiding wastage of resources but spending money on the most cost effective interventions and prioritizing primary care above hospital care.
7. Investment program should be made priority in States and hard to reach areas where basic infrastructure and human resources is inadequate

6.2.2 Stakeholders (NHIS, HMOs, Healthcare providers)

1. Capacity building for managers, administrators and key players to enable them manage the scheme through effective and efficient use of resource that will be generated.
2. Actuarial studies should be conducted to determine feasible premiums

based on income levels to make the scheme sustainable.

3. Develop a modest benefit package that reflect the disease burden of the country and progressively increase the benefit package as the scheme progresses.
4. Monitoring and evaluations: The health information system should be strengthened to assist in monitoring and evaluation of the scheme while regular auditing should be conducted to prevent mismanagement and corruption.
5. Transparency of the scheme should be ensured by involving the stakeholder in decision making, this will create a sense of ownership. There should be comprehensive education, sensitisation and promotion of all NHIS to the public. This can be achieved through the media campaigns and community engagement.
6. Internally generated funds from domestic revenue collection should be improve through an effective tax collection system.

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